Social, economic and professional barriers influencing midwives' realities in Bangladesh: a qualitative study of midwifery educators preparing midwifery students for clinical reality

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Abstract

Introduction. Identifying existing barriers inhibiting the provision of quality care in Bangladesh can guide both the government, in fulfilling its commitment to establishing the midwifery profession, and midwifery educators, in preparing midwifery students for the reality of midwifery clinical work.
Aim. The aim of this study was to describe midwifery educators' perceptions of midwives' realities in Bangladesh, focusing on social, economic, and professional barriers preventing them from carrying out quality care.
Methods. Data were collected through focus group discussions with 17 midwifery educators and analysed using qualitative content analysis, guided by the analytical framework "What prevents quality midwifery care?". Ethical clearance was obtained from Bangladesh's Directorate General of Nursing and Midwifery.
Results. The results generated by the application of the framework included social barriers of gender structures in Bangladeshi society. This influenced entry into midwifery education, carrying out midwifery work safely, and the development of the profession. Economic barriers included challenges for Bangladesh as a low-income country with a large population, inadequate salaries, and staff shortages, adding extra strain to midwives' working conditions. These social and economic barriers were further enhanced by professional barriers due to the midwifery profession not yet being fully established or acknowledged in the health system.
Conclusions and implications. The study presents novel country-specific perspectives but confirms the general underlying issues of gender inequality as a base for barriers preventing midwives from carrying out quality care, in line with the framework "What prevents quality midwifery care?". Addressing these structures can facilitate more students to enter midwifery education, enable quality midwifery work free from discrimination, and provide sufficient working space and professional integrity. Leadership training is pivotal to increasing responsiveness to the needs of the new cadre of midwives. Midwifery educators should take the lead in sensitising clinical supervisors, mentors, and preceptors about midwives' realities in Bangladesh.

Key words: Quality midwifery care, midwifery educators, Bangladesh, focus groups, evidence-based midwifery

Introduction

Midwifery care is identified as crucial for the improvement of maternal and child health. When provided at a high-quality standard, it has the potential to reduce maternal and neonatal mortality substantially, with an estimated 80% of all maternal deaths prevented through midwife-led family planning, maternal, and newborn health (Homer et al, 2014). A professional midwife works in partnership with women to provide sexual and reproductive health education, support and care throughout the woman's life cycle, including pre-pregnancy, pregnancy, labour and the postpartum period (International Confederation of Midwives (ICM), 2017a). Prerequisites for quality midwifery care are appropriate licenses for practice, regulated settings for the midwifery scope of practice, sufficient, effective, and proper use of existing resources, teamwork, and effective referral systems (Renfrew et al, 2014). Trained, licensed, motivated, and respected midwives, with sexual, reproductive, and perinatal health within their professional scope, are central in providing this care (Koblinsky et al, 2016; Renfrew et al, 2014). Midwifery educators are central links and leaders in ensuring that quality care, equity and education are provided to midwives and women (ICM, 2017b). To ensure that midwives are educated to the level required to provide evidence-based quality midwifery care, there is a need for high-quality education programmes run by well-educated and competent midwifery educators (Bharj et al, 2016; Way, 2016; Fullerton et al, 2013; Renfrew et al, 2014). According to a recent study, midwifery students in Bangladesh identified women's vulnerability and midwives' lack of recognition in the medical hierarchy as factors that leave midwives with low levels of autonomy (Bogren et al, 2018). As 60% of the midwifery education programme takes place in clinical placements, midwifery educators need to be well aware of the reality of clinical work so they can prepare their students for their new profession.

Bangladesh, with for a population of 163 million, is the tenth most densely populated country in the world (Worldbank, 2016) with approximately 3.1 million live births a year (Bangladesh

Bureau of Statistics, 2015). Only 47% of births take place in a healthcare facility; barely 50% of these are attended by a skilled practitioner and there is a high maternal mortality rate (MMR) of around 196 maternal deaths per 100,000 live births (NIPORT, ICCDR, MEASURE, 2016). The Ministry of Health manages the country's healthcare service, which is organised into four levels of care: primary level, secondary level, tertiary level and specialised hospitals. Due to the high MMR, the government has initiated a number of health-system strategies as a response to the global call for the provision of quality care through well-educated midwives in accordance to international standards (ICM, 2017a, 2013). It was anticipated that posting a larger number of well-educated midwives at healthcare facilities throughout Bangladesh would improve maternal and child health outcomes. With this as a backdrop, the Bangladeshi Government determined to educate and deploy professional midwives throughout the country (Bogren et al, 2017). A six-month post-basic midwifery programme for nurse-midwives and a three-year diploma in midwifery have been initiated, and a total of 1,600 professional midwives had graduated by 2016 (Bogren et al, 2017). Due to midwives being identified as crucial in the process of improving quality maternal and child health, extensive demands are placed on them, and in turn on midwifery educators whose job it is to prepare future midwives to deliver quality care to mothers and their offspring in the clinical reality they face.

The question what prevents quality midwifery care has been investigated globally in consultation workshops with midwives, focusing particularly on midwifery in middle and low-income countries. Workshops organised by the ICM, White Ribbon Alliance, and WHO resulted in the development of a framework identifying social, economic, and professional barriers (Filby et al, 2016; WHO, 2016). As the midwifery profession has only recently been introduced into the Bangladeshi health system, identifying existing barriers seen as inhibiting the provision of quality care can inform the government in fulfilling its commitment to establishing the midwifery profession and the midwifery educators in preparing the midwifery students for the clinical realities of practising midwifery. Building on this, we applied the framework to identify – from the perspective of midwifery educators – barriers inhibiting the provision of quality midwifery care in Bangladesh. This was to provide stakeholders and the new cadre of midwives in Bangladesh with country specific perspectives, which could resonate back to the global understanding of barriers to quality midwifery care.

The aim of this study was to describe midwifery educators' perceptions of midwives' realities in Bangladesh, focusing on the social, economic, and professional barriers that prevented them from carrying out quality care.

Method

A qualitative design (Elo and Kyngäs, 2008) was chosen with focus group discussions (FGDs) based on a semi-structured topic guide developed from a pre-existing framework about barriers to quality midwifery care (Filby et al, 2016). This allowed a study of midwifery educators' perceptions of the realities of midwifery in Bangladesh, reflected through the framework and their general perspectives, to inform the development of the theory base concerning quality midwifery care. A qualitative research design was applied, this being recognised as helpful when little is known about the phenomenon under study (Polit and Beck, 2012), such as Bangladeshi midwifery educators' perceptions of midwives' realities.

Study setting

The study was conducted at three public nursing institutes and colleges in three different settings in Bangladesh: in the capital city of Dhaka, in the semi-urban district of Tangail, and in the more remote city of Rangpur. Since 2012, these colleges and institutes have had a yearly intake of 25 midwifery students into a three-year diploma course in midwifery. Students enrolled in these midwifery programmes come from urban, semi-urban, and rural areas, and the majority of them live in dormitories attached to institutions and colleges during their studies and clinical practice. Clinical practice takes place both in city-based referral hospitals and in Upazila health complexes where midwifery care during pregnancy and delivery is provided. The midwifery educators involved in these diploma programmes have undergone either a six-month post-basic advanced midwifery training course or a one-month midwifery educator training course and they have clinical experience as nurses or nurse-midwives.

Participants and data collection

A total of 17 midwifery educators were purposively included as participants in the study, and a FGD with five to seven participants was conducted at each college or institute, ie, three FGD were undertaken. All participants were over 45 years of age and were living in urban areas. All but two were married with between one and four children.

Data were collected in April 2017 by faculty members at the three different sites, two faculty members at each site, under supervision from the researchers responsible for the study. The faculty members/data collectors were themselves students completing a master's degree in Sexual and Reproductive Health and Rights, in which qualitative data collection methods had been taught and practiced prior to the study. After permission had been granted from the principals and nursing instructors in charge at each college or institute, invitation letters were handed over personally to potential participants, together with oral information about the study. Time was given to consider participation. Seventeen midwifery educators agreed to participate in the study. Before conducting the FGDs, the voluntary nature and confidentiality of the study were explained to the participants, and oral and written consent was given by all participants. Bangladesh's Directorate General of Nursing and Midwifery has the main responsibility for activities that take place in the nursing and midwifery institutions in the country and it provided ethical clearance for the study, on 21 February 2017.

A topic guide, based on the analytical framework of barriers inhibiting the provision of quality care by midwifery personnel (Filby et al, 2016), was developed and used during the FGDs. This covered social, economic, and professional barriers. Using a semi-structured approach it included open-ended questions such as: "Previous research has shown that midwives are

sometimes treated badly or experience poor conditions in society. Have you heard of this happening in your society, related to… gender inequality? How? Lack of safety and security? Please describe (…) In your setting, are midwives' realities affected by practice restrictions? How? What makes you think this? During the discussions, the participants were encouraged to reflect and share their experiences freely. The FGD sessions were conducted in private settings at each institution, in both English and Bengali, to enable deeper discussions and understanding, and lasted up to one hour each. They were digitally recorded with the participants' permission.

Analysis

The recordings were transcribed verbatim and the Bengali parts were thereafter translated into English by an experienced translator, independent of the data collectors or research team. Accuracy of translation was confirmed by Bengali-speaking members of the research team to enhance the credibility of the study. Therefore, formal forward and back translation (Abujilban et al, 2012; WHO, 2005), was not deemed necessary.

The transcripts were analysed by content analysis described by Elo and Kyngäs (2008). Firstly, all transcripts were read several times in order to become familiar with the content. The second step was to search for units of meaning, consisting of descriptions corresponding to the aim. The third step was to group the meaning units together, after being compared for similar content. They were labelled and sorted into codes and sub-categories based on the different barriers in the framework. These sub-categories were then modified to mirror the collected data in an adequate way. The modified sub-categories were sorted into the broad categories social, professional, or economic barriers. The analysis was not a linear process and there was open and critical dialogue within the research team throughout, until the final terms were determined by consensus. Finally, the transcripts were re-read to verify the analysis and to find quotes illustrating variation in the meaning units.

Results

The results comprised the three categories: social barriers, economic barriers and professional barriers, each of which included three sub categories, see Table 1.

Table 1. Social, economic and professional barriers

Social barriers	Gender inequality permeates midwives' lives from childhood
	Violence in society continues in the workplace
	Disrespect for being young or single and working
Economic barriers	A new profession with a low salary
	Lacking support for housing and transport
	A huge population and shortage of staff lead to little or delayed leave
Professional barriers	Being absent from policy dialogue and unable to contribute to decisions
	Not being recognised as a skilled professional
	Lacking resources and space for practice

Social barriers

The category of social barriers included the sub-categories: gender inequality permeates midwives' lives from childhood, violence in society continues in the workplace, and disrespect for being young or single and working.

Gender inequality permeates midwives' lives from childhood

Study participants described how living in a society primarily dominated by men causes neglect and negative attitudes towards women's – midwives' – lives from birth to death:

"Our society is mainly dominated by the men, and their negative attitude towards women is seen everywhere in society. As women, midwives are neglected in society" (FGD2).

They outlined a perception among people that it is not necessary to educate female children, since they cannot both earn money and raise a family. Often controlled by males, women were described as having little power over financial issues, pregnancy or how many children they may have. The participants described having little possibility/potential to engage in decision making, and experienced that balancing unpaid domestic work and childbearing tasks with their professional role could prevent midwives from providing quality care. The cultural perception that females should not be working outside the home and had little right to move freely was even more pronounced when linked to working night shifts.

"Society has a view that the men are the main contributors to the family rather than the women. Extra care during childbirth is not needed; society thinks that education is not essential for women as they don't need to take on a profession or go outside their houses" (FGD2).

Violence in society continues in the workplace

The theme of male dominance – which resulted in a lack of empowerment for women – was evident within the data. The participants described how women are at risk of being violated and harassed in their own families or homes, outside their homes, and in the workplace. Thus, as a midwife, it could be difficult to move and work freely without being harassed or violated, particularly at night.

A lack of safety and security were partly ascribed to the overall working environment, where labour wards or emergency wards were open for anyone to enter.

"As women, midwives are also the subject of male attraction and these midwives are not able to move freely, even in the emergency care she won't go out alone especially in the night time" (FGD2).

Pressure, competition and neglect at work or during clinical placements was another theme which was raised, which the participants identified as a form of psychological violence. When placed in clinical practice, competition with intern doctors, student doctors, and other health workers

could affect midwifery students' opportunities to provide care for mothers. Completing their clinical duties in these cases was extremely difficult and required a large amount of mental strength:

"They face barriers that inhibit practice in the delivery ward. In Dhaka Medical College many students are from the nursing faculty and there are a huge number of student doctors who midwifery students need to compete with. Sometimes these students face psychological pressure and are not allowed to practice in the ward by their competitors. This is the violence they have been facing, but not physical violence" (FGD1).

The participants thus stated that midwives did not feel safe in their workplaces and concluded that if they were not fearful of being violated or neglected, they would have more courage, strength and space for providing quality care:

"The chance of being harassed, verbally bullied or physically and sexually abused – this affects their feelings of selfhood and prevents them from providing quality care" (FGD3).

Disrespect for being young or single and working

The midwifery profession is a young profession in Bangladesh and people are often unfamiliar with it, so they do not want to fully rely on the work midwives do. Linked to this is the fact that newly graduated midwives are often young and single:

"People think midwives are young and inexperienced so they don't trust their abilities. This is challenging for the midwives who are single and working" (FGD2).

Particularly challenging is the combination of being young, single and posted to rural areas lacking adequate accommodation. This causes new midwives to feel unsafe, vulnerable and at risk of being subjected to physical, psychological and sexual harassment and violence. So far a limited number been posted in remote settings, but these postings will gradually increase, and the midwifery educators pointed out the need to improve midwives' safety so they will be able to provide quality care in these remote settings:

"Midwives are not feeling safe in their workplaces. If they didn't have to feel afraid of being violated or neglected they could provide quality care. Workplaces need to be safe and secure because newly recruited midwives are mostly single so they need better safety" (FGD2).

Another aspect relevant to single midwives – with implications that belong at policy level – is that a midwife's salary is not enough to cover the basic living costs for single women lacking family support.

Economic barriers

Economic barriers comprise the sub-categories: a new profession with a low salary, lacking support for housing and transport, and a huge population and shortage of staff leads to little or delayed leave.

A new profession with a low salary

In Bangladesh, midwives belong to a new cadre that has no separate salary structure. Study participants described how midwives get the same salary as nurses, which made sense for some of the FGD participants, as midwives were considered to be "second class employees of the state" on the same level as the nursing profession. Others, however, claimed that midwives' salaries are not in line with similar professions, that they are actually too low and fail to cover basic living costs:

"The low salaries are not comparable with similar professions and not enough for fulfilling basic needs…" (FGD3).

The low salary structure permeates the midwives' profession throughout their careers, from being students to becoming teachers. Bangladesh is a low-income country, which has led to a high level of dependency on international donors to cover midwives' salaries. In addition salaries are low in comparison with the private sector, which has a negative impact on the quality of care:

"… their salaries are much lower than in the private sector, for this reason midwives cannot provide quality care" (FGD3).

The participants stated that raised salaries, incentives, recognition or awards would significantly increase staff satisfaction and professional motivation. This, in turn, would increase the output of the work performed by the midwives. Study participants therefore declared a need for the government to come forward and look into the issue of salaries within the midwifery profession.

Lacking support for housing and transport

As a new cadre, no accommodation or transport facilities have been provided by the government. Study participants described how midwifery students live in nursing hostels and dormitories, leading to a shortage of accommodation and an unacceptable living standard:

"There is an accommodation shortage and these midwifery students are now living in the nurses' quarters, which are being managed mutually" (FGD1).

In addition, midwifery students are subjected to stress caused by the accommodation's lack of safety and the pain of being separated from their family's guidance and support. Thus, entering midwifery education caused these future midwives triple tensions:

"Inadequate and unsafe accommodation and isolation from family support" (FGD3).

Study participants could see a potential problem in the future regarding the housing and transportation of midwives who were to be posted in more remote areas with their duties including being available for emergency calls. This would require intervention from the government to ensure they were supplied with adequate accommodation and transportation:

"The midwifery profession comes with sensitive and emergency care; she has to be prepared for emergency calls" (FGD3).

A huge population and shortage of staff lead to little or delayed leave

The participants stated that in order for quality care to be provided, rest and recreation should not be underestimated. They described some of the consequences of working as midwives in a country with a huge population. An imbalance in numbers between midwifery care providers and care receivers had effects on the midwives' private life and health.

"Bangladesh is a densely populated country – compared to maternity patients, midwives are few in number and they suffer from the workload. Sometimes these midwives don't

have their daily break for rest which makes them feel dull; there are few chances for recreation" (FGD2).

Due to staff shortages, midwives could be forced to work while ill or compensate for illness among colleagues. This, together with having little leave or breaks from their work, does not only affect the happiness of a midwife but also the quality of her work:

"If the midwife is sick she has to wait for her leave, or she won't get home on time, which makes a midwife unhappy and hampers her ability to provide quality care" (FGD2).

Professional barriers

A number of professional barriers to quality care were outlined and organised in the three sub-categories: being absent from policy dialogue and unable to contribute to decisions, not being recognised as a skilled professional, and lacking resources and space for practice.

Being absent from policy dialogue and unable to contribute to decisions

The participants described that when policies for midwifery practice are discussed and settled, it is not a given that representatives from the midwifery profession would be present. They mentioned occasions when the Midwifery Association had not been informed of meetings and policy dialogues. Thus, there is a risk that policies are made by other professionals who lack insight into how to improve the quality of midwifery care:

"Midwives have less opportunity to participate in policy dialogue and the authorities have often not placed the midwives in the policy dialogue, which gives them less scope to contribute in the decision making" (FGD2).

The participants ascribed this situation to the male-dominated structure of Bangladeshi society. One consequence of a patriarchal society is that women have little opportunity to be heard and contribute to decisions. This, they stated, is also apparent in how midwifery is approached in Bangladesh. One participant said:

"Men are the decision-makers for midwifery in our country and as women, midwives don't have the opportunity to raise their voices or contribute to any decision" (FGD2).

They concluded that if midwives could contribute to policy making, the quality of services would improve:

"For the betterment of this profession, a separate midwifery functional body needs to be put in place – one that is run by midwives, not by the others. If we could establish this sort of functional body we could provide better care" (FGD2).

Not being recognised as a skilled professional

Lack of recognition of midwives' skills was seen on several levels in society. Since midwifery is a new profession, the participants said that most people are unsure of the role or responsibilities of a midwife. They are often confused with nurses:

"Society doesn't know about midwifery and the role of midwives because it is a new profession. People confuse the nursing and midwifery professions. Still it is unrecognised to them" (FGD1).

A consequence of this lack of awareness was that participants felt that doctors are given a greater acceptance from people in society for mistakes in the care and treatments provided, but mistakes made by midwives are not tolerated in the same way. They hoped the acceptance of midwifery work would gradually increase over time.

Not even doctors and other health workers are familiar with midwives and their work. Sometimes these professionals questioned the knowledge and skills of the midwives:

"Sometimes nurses and doctors ask the midwives questions about their activities – why they do things in such a way? And there is the other problem of not getting the chance (to do their work)" (FGD1).

Participants said that due to the midwifery profession not yet having gained public awareness, people do not recognise or trust their work. Another issue brought up was that the young age of new midwives contributes to their lack of recognition. One participant stated that:

"Because of their young age, they don't get a proper chance to practice. They are questioned about their capability and knowledge" (FGD1).

Participants identified several ways of improving their recognition, status and working situation. An increase in salary was one way, offering refreshment training courses for midwives was another, and a third was promoting midwives' attendance at conferences or knowledge-sharing sessions.

Further, it was concluded that recognising midwives' capabilities to perform a good job is effective for work satisfaction as well as for the quality of care, and healthcare managers, professionals and lay people could all contribute to this. One participant shared a personal experience:

*"I was on vacation somewhere and standing on the bank of a river. A couple recognised me and came closer. The man asked me; 'Do you work in the Dhaka Medical?' I said 'Yes'. He said 'My wife had eclampsia and you treated her very well, she is in good health now'. The couple invited me to go to their home. It was a wonderful feeling – people never forget the faces they have seen in their critical time" (*FGD1).

Lacking resources and space for practice

Clinical practice is one of the most important parts of the teaching and learning activities of midwifery students. A midwife must practise hands-on alongside theory but participants identified several barriers inhibiting this.

Of particular concern was the lack of space for practice. The participants described how midwifery students and midwives face barriers inhibiting hands-on training in hospitals:

"During practice sessions all other students from different faculties come together within the scheduled midwifery practice so midwives get limited scope for practice" (FGD2).

This was ascribed to the domination of medical doctors and nurses in the clinical areas:

"They don't get a proper chance to be trained in the labour ward because of the domination of doctors and nurses" (FGD1).

If a midwife were to practice independently, this would contribute positively to the retention of midwives. One participant stated that a midwife allowed to practice independently would never consider leaving the profession.

The midwifery educators further described the need for

additional resources for the teaching institutions as well. A lack of teachers, clinical preceptors, and mentors for the midwifery students while in clinical practice made it difficult to support the future midwives in their practice of quality care:

"It isn't possible to mentor everyone because we have a shortage of teachers, supervisors, and mentors" (FGD1).

Due to the shortage of teachers, midwifery students often have to learn by themselves. The midwifery educators asked:

"…if we don't teach them with quality education how can they become quality midwives?" (FGD1).

A third reason behind the limited practice opportunities was a lack of supplies and equipment, or lack of maintenance of the resources available. Participants described Bangladesh as a developing country where there are limited material resources available for the work carried out in the hospital. This shortage of supplies and equipment has a direct effect on the midwives and the midwifery students' opportunities to practice midwifery care in order to reach the desired standard:

"The supplies of equipment are not adequate to perform the work. This lack of supplies means that the midwives have not been performing quality midwifery care" (FGD3).

The need for a systematic working environment was raised, an environment in which everyone knows their responsibilities and can be accountable for their own duties and actions. Further, the importance of teamwork was highlighted, from support staff all the way up to the doctors and head nurses of the wards and departments. This was seen as essential, both to support the training of midwifery students and to make the most of the limited materials and resources available.

Discussion

The aim of this study was to illuminate midwives' realities in Bangladesh based on the Filby et al (2016) professional mapping framework: "What prevents quality midwifery care?", from the perceptions of midwifery educators. The midwifery educators participating in the study described structures in society that influence the possibilities to enter into midwifery education, to carry out midwifery work safely and to contribute to the development of the profession. As a low-income country with a large population, inadequate salaries and a shortage of staff add strain to midwives' realities. These barriers are further enhanced by the midwifery profession's relatively recent development in Bangladesh. As an increasing number of new midwifery students are now being trained, this study illuminates important underlying factors that may inhibit both the quality of care and the retention of midwives in the midwifery workforce. Participants highlighted the need for awareness of the significance of midwifery and the midwifery profession to be increased in the country, and how a lack of understanding of midwifery can negatively influence quality care. In line with this, midwives in Jordan have described the "invisibility" of midwives as a risk factor related to decreased confidence, which subsequently can support the trend of medicalising childbirth when their voices are not heard (Shaban et al, 2012). Several studies have elaborated on how this awareness also needs to be increased at government level to influence policies made and to ensure sufficient investments are made in midwifery education and services, and at the workplace level, where midwifery work needs to be acknowledged and valued (Filby et al, 2016; Gualda et al, 2013; Shaban et al, 2102; Büscher et al, 2009). Our study findings support the calls for increased public and professional promotion of midwifery, not the least from other healthcare cadres (Gualda et al, 2013; Shaban et al, 2012) and highlight further the need to raise the awareness of the importance of midwives and midwifery care among people in general society. In future research it would be worth investigating the understanding of midwifery among physicians and nurses, given the different philosophical bases.

A significant barrier, permeating all layers, is gender discrimination and non-empowerment of women. This echoes several of the included studies in the Filby framework, concluding that fundamental to the process of improving the quality of midwifery care is addressing underlying gender structures since these influence midwives' lives, possibilities, and positions (Bogren et al, 2018; Filby et al, 2016). The participants in our study described how midwives are targeted by these inequalities in both direct and indirect ways, from childhood onwards, and how this even leads to being subjected to structural (Galtung, 1990) or inter-personal violence (Krug et al, 2002). Thus, the findings of this study can be used by midwifery educators to reflect together with their students on social barriers inhibiting the provision of quality care.

A societal factor with relational implications relates to the education and respect for women's skills and possibilities. A prevailing hesitance in supporting young women entering midwifery education, and the risks of midwives being harassed, was described. A positive trend has been seen in Bangladesh in recent years, both in societal norms related to female education (Blunch and Bordia Das, 2015) and in the proportion of women completing secondary education and university degrees (The Asian Development Bank, 2017). Linked to this are trends where the wage gap between the genders has narrowed, although these positive changes are not evenly distributed over all income classes (Ahmed and McGillivray, 2015). However, barriers related to gender do prevail (Haider, 2012), and the country scored 'very high' in gender discrimination against women in social institutions in 2014 (Social Insitutions and Gender Index, 2014). There is still a way to go to reach equal prerequisites that can lower the threshold for women entering midwifery education and enable quality midwifery work without the risk of harassment or physical safety.

On a policy level, study participants described frustration when they are not able to contribute to decision making due to a lack of presence in policy dialogues, which may hamper quality midwifery care. A link to gender was visible through participants' associations to a male-dominant society. This resonates with Filby et al (2016) and is similar to findings in a study of midwifery students' perceptions of barriers inhibiting quality midwifery care (Bogren et al, 2018). Bogren et al (2018) also described a lack of political understanding for midwifery, in many settings influenced by midwifery being less valued due to its focus on "women's issues". The gendered structures outlined in our study underscore the need for a strong professional association, which can advocate for midwifery in policy making. In line with this, the RCM has been funded by United Nations Population Fund to assist in strengthening the

midwifery associations globally.

Workplace level and professional relations: study participants raised the need for space to practice as midwives, both in terms of professional integrity and respect. Once midwifery students have learned the importance of, and how to provide, quality care they face the reality of being unable to perform tasks in the way they have been taught, which increases their risk for stress of conscience. Stress of conscience, which can be described as negative stress burdening a person's conscience (Glasberg et al, 2008) has linked health are professionals to burn out, intentions to quit, and a reduced quality of the care provided (Bremnes, et al, 2018; Lo et al, 2018; Åhlin et al, 2014; Juthberg et al, 2008). Awareness of the consequences of this negative spiral is central, particularly among management staff. Support, or a lack of support, from superiors is shown to influence the effects of stress of conscience (Åhlin et al, 2015; Glasberg et al, 2008) as well as the quality of care (Tibandebage et al, 2015), which corresponds with findings in our study. This points to a need for leadership training to increase the responsiveness to the needs of staff (Madede et al, 2017). Additionally, it is pivotal to actively raise understanding among management, midwifery students and clinical staff in different positions regarding the impact of attitudes and hierarchies in the work place.

Methodological considerations

The choice of a qualitative approach, methodology and theory (Filby et al, 2016) provided novel perspectives of midwifery educators in a setting where the midwifery profession is newly established. The data was collected in institutions at three diverse sites from 17 purposively included midwifery educators, and based on their different experiences in FGDs with five to seven midwifery educators at each college/institute. A quantitative or mixed methods approach can be developed from this limited qualitative study to enable trustworthiness and generalisation of the results and thereby provide a more solid platform for improving quality midwifery care in Bangladesh. The findings should, hence, only be cautiously transferred to other non-similar contexts, as the qualitative study design does not allow generalisations.

The data collectors were bilingual English and Bengali speakers, which strengthens the credibility and richness of the data, since the participants were free to use their native language if needed. To strengthen the quality of transcription and translation of the data, an experienced translator, independent from the research team or data collectors, with no previous knowledge of the topic guide (Abujilban et al, 2012; WHO, 2005), transcribed the Bengali parts to English. Bengali-speaking members of the research team thereafter verified the translations. Therefore, no formal back translation into Bengali was deemed necessary. The data collectors were familiar with local contexts, which strengthens the credibility of the study.

The data collection performed by different data collectors in the different sites may constitute a weakness affecting dependability, but this was to some extent compensated for by using a design with the same detailed topic guide at each site. A well-described and structured analysis method (Elo and Kyngäs, 2008) and similar findings in other studies (Bogren et al, 2018; Filby et al, 2016) further strengthen the trustworthiness of the study. Using a framework in the data gathering and analysis can be seen as a limitation. Not focusing on both barriers and facilitators could be a source of bias with pre-set ideas and attitudes. The topic guide based on the framework may have narrowed the perspectives derived from the participants. The impression of the results can easily be that it is a lack of independent innovation. To limit this risk, the discussions were open, with room for the participants to narrate freely as long as the topic was related to the aim. Despite the limitations, novel perspectives were found and interpreted in the context of other studies in the discussion section. These findings can provide a base for further research and development initiatives for women and midwives realities in Bangladesh.

Conclusions and clinical implications

Economic barriers, gender inequality and discrimination, plus professional barriers such as lack of integrity might prevent skilful young women from entering midwifery and providing quality care. To improve quality midwifery care in Bangladesh, effort is needed on all levels. Addressing unequal gender structures can lower the threshold for entry into midwifery education, enable quality midwifery work free from discrimination or physical safety risks, and provide space where midwives can work with professional integrity. Midwifery educators can take the lead in sensitising clinical supervisors, mentors, and preceptors about midwives' realities in Bangladesh. This includes encouraging them, together with the midwifery students, to reflect on caring actions for the provision of quality care in situations where women are vulnerable in society and midwives have low autonomy in the workplace. Leadership training for management can increase responsiveness to the needs of this new cadre of midwives and raise understanding among all cadres of staff regarding the impact of attitudes in the work place. A strengthened professional association can advocate for midwives' roles and mandate. At a unique time in midwifery practice in Bangladesh there is an opportunity to inform and strengthen the practice of midwifery educators and midwives to provide the care for women that they are trained to give.

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